New York State Department of Health

Health Equity Impact Assessment Template

Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

SECTION A. SUMMARY

1. Title of project	Conversion of Subacute Care Beds to Ventilator-Dependent Beds
2. Name of Applicant	Pathways Nursing and Rehabilitation Center
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	OckhamHealth Strategists Janine Logan, JLogan@ockhamhealth.com Hannah Moore Brooke Oliveri
4. Description of the Independent Entity's qualifications	Suburban Hospital Alliance of New York State, LLC provides health equity independent assessment services through its OckhamHealth Strategists service line. Operating under SHANYS, OckhamHealth Strategists has demonstrated experience in health equity, community health and stakeholder engagement. Our staff directed the state's Population Health Improvement Program for five years, wherein we developed relationships with a broad array of community stakeholders and deployed a collective impact model that incorporated social determinant of health factors, health equity, health literacy, cultural competency, and health disparity reduction. Staff in all projects take into consideration the community context in which a proposed project is found. This translates into a historical scan of structural racism and other discriminatory practices that may affect any one medically underserved group's ability to access fair and equitable care. OckhamHealth Strategists staff members have undergone extensive racial justice training to enhance systemic analysis skills and to implement and sustain actions that advance racial equity in the practice of public health and health policy. We helped develop a community health needs assessment data-driven, turnkey service to assist hospitals and public health departments in fulfilling community assessment and intervention plan requirements. The service draws from our extensive field work in conducting meaningful

	engagement through key informant interviews, focus groups, listening sessions, and town halls and our qualitative analysis capabilities. In addition, we are engaged in local and regional initiatives to improve the health of our communities and strengthen the healthcare workforce. In the Long Island region, SHANYS has a twenty-year history of leadership in providing health insurance enrollment assistance. During the COVID-19 pandemic, we played a key role in coordinating the vaccination program with the region's hospitals, community health centers and health departments, working to ensure that marginalized communities had access to vaccinations. We have administered a variety of DOH and DOL healthcare workforce grants through the years, assisting current hospital employees and others interested in healthcare careers to become certified nursing assistants, surgical techs, and similarly skilled positions. Other grants have helped prepare nurse preceptors and nurse faculty. In all of our projects, we maintain a commitment to diversity and inclusion. SHANYS also helped to bring together hospitals, county health departments and other providers to establish the Mutual Aid Coordinating Entity (MACE) in the Hudson Valley region to ensure regional collaboration and partnership during health emergencies and continues to coordinate regional preparedness activities. For many years, it also served as a federally designated Patient Safety Organization, bringing together clinicians across the region in collaboration around best practices to improve patient safety and healthcare quality. Our lead staff member for HEIA projects is also an assistant professor of community health at a state university and sits on several regional and statewide health equity task forces.
5. Date the Health Equity Impact Assessment (HEIA) started	January 16th, 2026
6. Date the HEIA concluded	March 31st, 2026

7. Executive summary of project (250 words max)

Pathways Nursing and Rehabilitation Center is a 110-bed skilled nursing facility located in Niskayuna, NY. The facility proposes to convert twelve of its subacute beds to ventilator beds in order to provide care for additional ventilator-dependent patients. This project will result in a total of 36 available ventilator beds. Pathways Nursing and Rehabilitation Center is the only skilled nursing facility offering adult ventilator beds in the Capital Region of NY, caring for New Yorkers residing in areas north of Greene County and east of Delaware County.

8. Executive summary of HEIA findings (500 words max)

Based on the findings of this HEIA, this project will enhance access to mechanical ventilation care among all adults living in the Applicant's service area. The Applicant is the only facility offering adult ventilator-dependent beds in the Capital District of New York State. With just 24 beds available, local services are consistently at- or near-capacity. This results in barriers for hospital staff members and caregivers in coordinating ongoing ventilator care for patients. The expansion of ventilator services will increase the ease in which hospitals can identify and arrange post-acute care for patients, ultimately streamlining care processes and enhancing continuity of care. For patients residing in the counties immediately surrounding the Applicant, this enables patients to receive services close to home and enhances the ability of loved ones to visit during their course of care.

The IE also reports that, while this project will require the conversion of subacute care beds to ventilator-dependent beds, this is not expected to substantially or negatively impact medically underserved communities living in the service area who require subacute care. Based on the demonstrated capacity constraints and barriers to identifying ongoing care for ventilator-dependent patients, the IE expects that the benefit of offering additional ventilator services will far outweigh any unintended impacts of the loss of subacute care beds. This is especially true in considering that there are significantly more residential healthcare programs offering subacute care throughout the service area than those with ventilator units.

This project will benefit all patients who require mechanical ventilation services. Still, this is likely to have the greatest impact on groups at increased risk for acute respiratory failure, groups who utilize prolonged ventilation services at greater rates, and/or those that experience disparate access to these services. Accordingly, the groups expected to be most impacted by the proposed project include older adults, people living with a prevalent infectious disease or condition or a disability, people living in rural areas, people with low income, racial and ethnic minorities, and people with public healthcare coverage.

Based on meaningful engagement with community members, patients, employees of the facility, and representatives of local health departments, this project is widely supported by individuals living in the service area.

Overall, it is the Independent Entity's opinion that this project will have a positive impact on the community.

SECTION B: ASSESSMENT

For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.

STEP 1 – SCOPING

1. Demographics of service area: Complete the "Scoping Table Sheets 1 and 2" in the document "HEIA Data Tables". Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.

This file is complete for the 398 residential zip codes that comprise the program's service area.

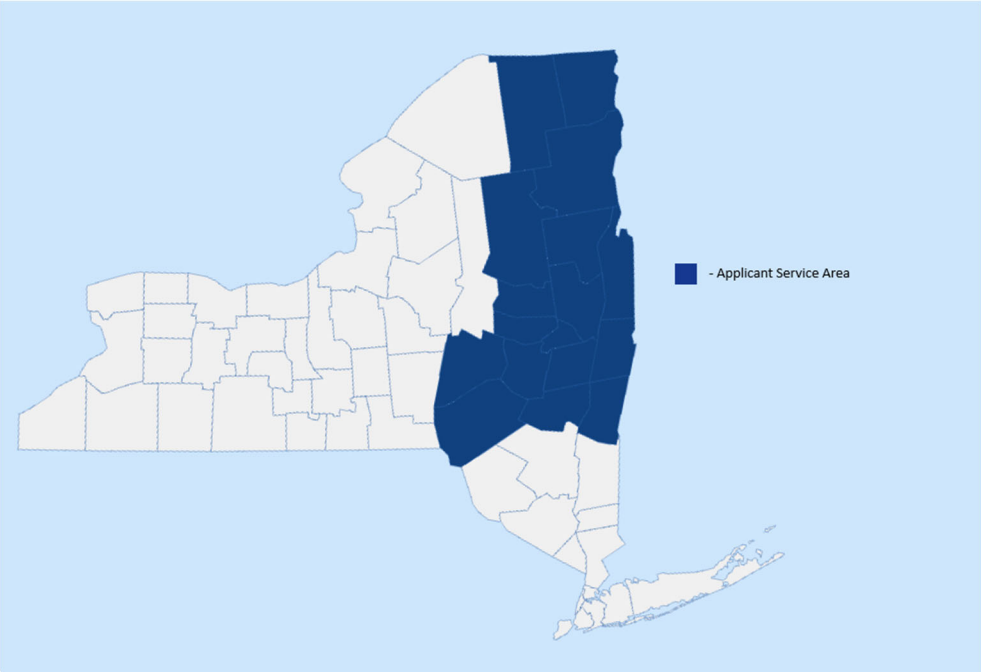
2. Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:

   - ❑ Low-income people
   - ❑ Racial and ethnic minorities
   - ❑ Immigrants
   - ❑ Women
   - ❑ Lesbian, gay, bisexual, transgender, or other-than-cisgender people
   - ❑ People with disabilities
   - ❑ Older adults
   - ❑ Persons living with a prevalent infectious disease or condition
   - ❑ Persons living in rural areas
   - ❑ People who are eligible for or receive public health benefits
   - ❑ People who do not have third-party health coverage or have inadequate third-party health coverage
   - ❑ Other people who are unable to obtain health care
   - ❑ Not listed (specify):

The Applicant's service area includes 398 residential zip codes spanning 17 counties in the Capitol District, Mohawk Valley, and North Country of New York State (NYS) as shown by the map below. The total resident population of the service area is 1,504,543.[1] The sociodemographic profile of these residents is outlined below.

[1] American Community Survey 5-Year Data (2019-2023)

Figure 1. Applicant Service Area



Source: MapChart

Sociodemographic Profile of Residents Living in the Applicant Service Area

- **People with low-income** – With such a vast service area, the economic means of residents vary greatly. The proportion of individuals living below the Federal Poverty Level (FPL) sits at 11.2 percent for the entire service area. Franklin County and Delaware County report the highest rates of families living below the FPL, reaching 16.5 percent and 14.9 percent, respectively. Throughout the service area, the proportion of individuals who are unemployed is 2.9 percent and 2.7 percent receive cash public assistance.
- **Gender** – Of the 1.5 million residents living in the service area, 50.2 percent are female, and 49.8 percent are male.
- **Age** – Approximately 19.8 percent of residents living in the service area are older adults aged 65 years or older. This rate is slightly greater than the proportion of older adults living across New York State (17.4 percent). Approximately 21.8 percent of residents are children or adolescents, 31.6 percent are between the ages of 20 and 44 years old, and 26.8 percent are middle-aged adults between the ages of 45 and 64.
- **Race, ethnicity, and immigration status** – Most residents (82.3 percent) living in the service area are white. Residents identifying as Black or African American are the largest (5.8 percent) racial/ethnic group living in the service area, followed then by Asian community members (3.3 percent). Less than one percent of residents identify as American Indian or Alaska Native (0.4 percent). Six percent of community members identify as multiracial and 2.2 identify as another race. Just over five percent of residents living in the service area identify as

Hispanic or Latino (5.6 percent) and 6.7 percent of individuals residing in these regions were not born within the United States. Approximately 8.4 percent of individuals living in the service area report speaking a language other than English in the home, including 3.4 percent of residents who speak another Indo-European language and 2.7 percent who speak Spanish.

- **People with disabilities** – Over 210,000 residents (14.1 percent) living in the service area report living with a disability. Ambulatory difficulties are the most common disability experienced by service area residents (6.5 percent), followed then by cognitive difficulties (5.7 percent), independent living difficulties (5.2 percent), hearing difficulties (3.9 percent), self-care difficulties (2.3 percent), and vision difficulties (2.2 percent).[1]
- **Persons living with a prevalent infectious disease or condition** – Throughout the 17 counties in the service area, 3,075 individuals live with HIV and AIDS.[2] In 2024, there were nine new cases of tuberculosis across these counites, most of which occurred in Albany County.[3] There were also 411 newly reported cases of Hepatitis C and 156 new cases of Hepatitis B in the region.[4]
- **Lesbian, gay, transgender, or other-than-cisgender people** – Throughout the 17 counties, 1.2 percent of residents identify as gender-diverse and 7.1 percent report a sexual orientation other than straight.[5]
- **People living in rural areas** – According to information provided by Rural-Urban Commuting (RUCA) codes, 41.9 percent of the 1.5 million residents living in the service area are considered to reside in a rural area.[6]
- **People who are eligible for or receive public health benefits** – Of the nearly 800,000 households in the service area, 11.1 percent received food assistance in the past twelve months, five percent receive Supplemental Security Income, and 2.7 percent receive cash public assistance income.[1]
- **People who do not have third-party health coverage or have inadequate third-party health coverage** – Approximately 3.5 percent of service area residents do not have health insurance. Of the 1.5 million residents, approximately 40.9 percent utilize public health insurance coverage. Medicaid and Medicare are the most common forms of public health insurance coverage for service area residents, with approximately 22 percent of the population using each insurance coverage alone or in combination.[1]

[2] New York State HIV/AIDS Annual Surveillance Report (for persons diagnosed through December 2024)

[3] New York State Department of Health, Bureau of Tuberculosis Control: Tuberculosis Cases and Rates by County, New York State, 2020-2024

[4] New York State Department of Health Aids Institute, Bureau of Hepatitis Health Care and Epidemiology: Hepatitis B and C Annual Report 2024

[5] Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2021 – https://www.cdc.gov/brfss/annual_data/2021/pdf/2021-weighting-description-508.pdf

[6] 2020 Rural-Urban Commuting Area (RUCA) Codes

3. For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?

- American Community Survey 5-Year Data (2019-2023)
- Data/information from the Applicant
- Meaningful engagement responses
- New York State Department of Health, Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, Behavioral Risk Factor Surveillance System, Year 2021
    a. *Disclaimer: The data used to produce this publication comes from New York State Department of Health, Behavioral Risk Factor Surveillance System (BRFSS). However, the calculations, metrics, conclusions derived, and views expressed herein are those of the author(s) and do not reflect the work, conclusions, or views of NYSDOH, BRFSS. NYSDOH, BRFSS, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.*
- New York State HIV/AIDS Annual Surveillance Report (for persons diagnosed through December 2024)
- New York State Department of Health Bureau of Tuberculosis Control (Tuberculosis Cases and Rates by County, New York State, 2020-2024)
- 2020 Rural-Urban Commuting Area (RUCA) Codes
- Office of Health Services Quality and Analytics, Statewide Planning and Research Cooperative System (SPARCS)
    a. *Disclaimer: The data used to produce this publication comes from New York State Department of Health ("NYSDOH"). However, the calculations, metrics, conclusions derived, and views expressed herein are those of the author(s) and do not reflect the work, conclusions, or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.*

4. How does the project impact the unique health needs or quality of life of <u>each</u> medically underserved group (identified above)?

The conversion of subacute beds to ventilator-dependent beds proposed by the Applicant will increase access to ventilator care. These beds will service any individual suffering from an injury, disease, or respiratory complication requiring mechanical ventilation. This includes both individuals who may be weaned off of ventilator care to independent breathing or those who face long-term ventilation and require continuous monitoring and/or care rendered by the skilled nursing facility. Ventilator dependency may result from spinal cord injury, lung injury, chronic respiratory diseases, or neurodegenerative and neuromuscular disorders.[7] As a result, the overall patient

[7] Sahetya, S., Allgood, S., Gay, P. C., & Lechtzin, N. (2016). Long-Term Mechanical Ventilation. *Clinics in chest medicine*, *37*(4), 753–763. https://doi.org/10.1016/j.ccm.2016.07.014

population utilizing the proposed beds may be impacted by a vast array of illnesses or injuries resulting in respiratory failure or complication, all of which have unique considerations for various medically underserved groups.

The conversion of beds from subacute care to ventilator-dependent care will benefit all patients who require ventilation. Still, groups at greatest risk for acute respiratory failure, which is recognized as the most common indicator for the initiation of mechanical ventilation, are likely to benefit most markedly from the expansion of ventilator services.[8] Other groups that evidently utilize prolonged ventilation services at greater rates and/or experience disparate access to these services will also benefit more substantially. Overall, the groups expected to be most impacted by the proposed project include older adults, people living with a prevalent infectious disease or condition or a disability, people living in rural areas, people with low income, racial and ethnic minorities, and people with public healthcare coverage. The unique health needs of these groups are discussed below. It is important to note that because this project will impact individuals suffering from a vast array of illnesses and injuries throughout 17 counties, research on the unique health needs of ventilator-dependent, medically underserved individuals was best developed by consulting the existing body of scientific literature, rather than local, granular sources.

Older adults

As detailed further in Scoping Question #5 below, a majority of patients receiving ventilator care in the Applicant service area are 65 years of age and older. While ventilation may occur after trauma or illness impacting individuals of any age, age is strongly associated with the risk of respiratory failure.[9] Accordingly, individuals aged 65 and older are most likely to utilize the converted beds for ventilator services. This group is expected to be most substantially impacted by the expansion of this care at the Applicant facility, especially in considering that this service area has a higher proportion of individuals aged 65 and older than the state overall.

Persons living with a prevalent infectious disease or condition

Mechanical ventilation may occur as a result of a wide variety of prevalent infectious diseases or conditions impacting the brain or spinal cord, the lungs, or airways. This may include common respiratory illnesses such as COVID-19, RSV, or influenza resulting in pneumonia or respiratory distress, chronic pulmonary infections like tuberculosis, and neurological diseases like bacterial meningitis.[9] In cases of severe infectious disease resulting in mechanical ventilation, patients are likely to be cared for in a hospital and referred to a skilled nursing facility when the acute symptoms of illness

[8] Hong, S. B., Oh, B. J., Kim, Y. S., Kang, E. H., Kim, C. H., Park, Y. B., Han, M. S., Shin, C., & Korean study group on respiratory failure (KOSREF) (2008). Characteristics of mechanical ventilation employed in intensive care units: a multicenter survey of hospitals. *Journal of Korean medical science*, *23*(6), 948–953. https://doi.org/10.3346/jkms.2008.23.6.948

[9] NIH. (2022, March 24). Respiratory Failure - Causes and Risk Factors | NHLBI, NIH. Www.nhlbi.nih.gov. https://www.nhlbi.nih.gov/health/respiratory-failure/causes

are managed and the risk for transmission is lessened. As such, patients who are ventilated as a result of an infectious disease will benefit from the expanded ventilator capacities occurring as a result of this project.

Persons living in rural areas

According to an analysis of individuals living in the service area, 41.9 percent of community members serviced by the Applicant facility reside in a rural area. Scoping Question #6 below exemplifies the few facilities in or near the Applicant service area that provide ventilator services. This project will increase access to ventilator services among all residents of the service area. This is especially crucial considering the significant service area population living in a rural area with considerably less access to health care facilities with ventilator capacities.

Women

Available literature reports variable findings on sex-specific differences among patients requiring prolonged mechanical ventilation. Some researchers report no gender differences in patients requiring prolonged ventilation, while others report that men are statistically more likely to require invasive long-term ventilation.[10,11] Accordingly, this project is unlikely to have a differential impact on patients of varying sex or gender-identities. All patients requiring mechanical ventilation will benefit from the expansion of services.

People with low income

Income is associated with numerous factors that influence respiratory health. An evaluation of lung health among individuals of varying socioeconomic standing between 1959 and 2018 showed that, despite sweeping advancements in air quality, tobacco control, occupational safety, and medical care, low-income community members remain subject to worse lung health outcomes.[12] These respiratory conditions may increase the likelihood of individuals requiring mechanical ventilation. Therefore, patients with low income may be at greater risk for requiring the services of the additional ventilator-dependent beds proposed by this project and would benefit more markedly from the expansion of these services at the Applicant facility. This is crucial for enhancing access

[10] Huang C. (2022). Gender Differences in Prolonged Mechanical Ventilation Patients - A Retrospective Observational Study. International journal of general medicine, 15, 5615–5626. https://doi.org/10.2147/IJGM.S368881

[11] Trudzinski, F. C., Neetz, B., Dahlhoff, J., Höger, P., Kempa, A., Neurohr, C., Schneider, A., Herth, F. J. F., Joves, B., Szecsenyi, J., Biehler, E., Fleischhauer, T., Schubert-Haack, J., Grobe, T., Frerk, T., & PRiVENT-Study Group (2025). Sex-specific differences in risk factors and outcomes for long-term mechanical ventilation: a longitudinal cohort analysis of claims data. Scientific reports, 15(1), 35051. https://doi.org/10.1038/s41598-025-22399-z

[12] Gaffney, A. W., Himmelstein, D. U., Christiani, D. C., & Woolhandler, S. (2021). Socioeconomic Inequality in Respiratory Health in the US From 1959 to 2018. JAMA internal medicine, 181(7), 968–976. https://doi.org/10.1001/jamainternmed.2021.2441

to ventilator services among the 11.2 percent of service area residents living below the FPL.

Racial and ethnic minorities; Immigrants

Existing literature on the incidence of respiratory failure and related health outcomes reveals disparities among racial and ethnic minorities. These disparities are most extensive among individuals identifying as Black or African American. According to researchers, this group experiences increased incidence of respiratory failure and mortality resulting from respiratory failure. Other minority groups, including Asian residents, Native Hawaiian and Pacific Islanders, Indigenous Americans, and individuals identifying as Hispanic or Latino, also face respiratory health disparities, though this varies by respiratory illness and outcome measure.[13] Researchers report that the COVID-19 pandemic significantly contributed to worsening disparities among racial and ethnic minorities with respiratory failure.[14] A study evaluating the risk of severe COVID-19 infection showed that immigrants were more likely to require mechanical ventilation than their native-born counterparts.[15]

The influence of systemic barriers to health, such as long-standing residential segregation, community disinvestment, and income inequality, must be considered in evaluating racial disparities. Adverse health outcomes experienced by communities of color throughout the COVID-19 pandemic were intrinsically related to social determinants of health among these groups.[16] There is also evidence for medical device bias, particularly related to pulse oximetry, among individuals with darker skin tones that may result in undetected hypoxemia and delayed care.[14]

As such, the conversion of these beds to ventilator-dependent care at the Applicant facility will increase access to skilled-nursing care for individuals requiring lifetime mechanical ventilation and those who may be weaned from such. In considering the group's increased risk for respiratory failure and adverse respiratory health outcomes, patients identifying as a racial or ethnic minority and/or immigrant are likely to benefit from this expansion of ventilator services. The Applicant also reports that multilingual staff members and language access services are available on-site to enhance the ability of patients, including those who speak a language other than English, to communicate

[13] Bime, C., Poongkunran, C., Borgstrom, M., Natt, B., Desai, H., Parthasarathy, S., & Garcia, J. G. (2016). Racial Differences in Mortality from Severe Acute Respiratory Failure in the United States, 2008-2012. *Annals of the American Thoracic Society*, *13*(12), 2184–2189. https://doi.org/10.1513/AnnalsATS.201605-359OC

[14] Blank, J. A., Armstrong-Hough, M., & Valley, T. S. (2023). Disparities among patients with respiratory failure. Current opinion in critical care, 29(5), 493–504. https://doi.org/10.1097/MCC.0000000000001079

[15] Nordberg, P., Jonsson, M., Hollenberg, J., Ringh, M., Kiiski Berggren, R., Hofmann, R., & Svensson, P. (2022). Immigrant background and socioeconomic status are associated with severe COVID-19 requiring intensive care. Scientific reports, 12(1), 12133. https://doi.org/10.1038/s41598-022-15884-2

[16] Brakefield, W. S., Olusanya, O. A., White, B., & Shaban-Nejad, A. (2022). Social Determinants and Indicators of COVID-19 Among Marginalized Communities: A Scientific Review and Call to Action for Pandemic Response and Recovery. Disaster medicine and public health preparedness, 17, e193. https://doi.org/10.1017/dmp.2022.104

with their care team and receive equitable care. These services should mitigate language and cultural barriers and enhance communication with patients.

People living with a disability

As stated above, mechanical ventilation may be needed due to a variety of illnesses and injuries, many of which may result in disability. For example, those with spinal cord injuries or neurodegenerative and neuromuscular disorders are at greater risk for ventilation.[7] Therefore, this project will result in expanded access to ventilator care among individuals living with a disability. The proposed beds may be used by disabled individuals who will be weaned off of the ventilator or as long-term or end-of-life care for individuals with chronic respiratory failure.

Lesbian, gay, bisexual, transgender, or other-than-cisgender people

Ventilator use among individuals identifying as LGBTQIA+ is largely understudied. Still, all patients who are gender-diverse and/or identify with a sexual orientation other than straight who require mechanical ventilation will benefit from increased access to ventilator services.

People who do not have third-party health coverage or have inadequate third-party health coverage; People who are eligible for or receive public health benefits

Research on access to skilled-nursing facilities for prolonged ventilation among individuals with varying insurance statuses is scarce. Still, it is known that Medicaid and Medicare are the main funders for services rendered to ventilator-dependent patients residing in a skilled nursing facility.[17] Accordingly, over 80 percent of patients living in the service area who required mechanical ventilation care between 2018 and 2023 were insured by Medicare and/or Medicaid. Furthermore, most ventilator-dependent patients are first seen in a hospital setting where ventilation is carried out. It is often here that appropriate alternative care settings, such as skilled nursing facilities, are discussed. The decision to transfer a patient to a nursing home must take into consideration the availability of nearby facilities with ventilator services, the availability of ventilator-dependent beds, the level of support at home, and insurance coverage. It is expected that case managers in the hospital will assist in identifying care options for uninsured and underinsured patients. This may include providing support in enrolling an uninsured patient in Medicaid or Medicare for coverage of prolonged ventilation.

It is therefore likely that patients that utilize the converted ventilator-dependent beds will be primarily insured by Medicare and/or Medicaid. These individuals may also be eligible for public health benefits. The facility also accepts private insurance. Ultimately,

[17] Keohane, L. M., Mart, M. F., Ely, E. W., Lai, P., Cheng, A., Makam, A. N., & Stevenson, D. G. (2022). Establishing Medicaid incentives for liberating nursing home patients from ventilators. Journal of the American Geriatrics Society, 70(1), 259–268. https://doi.org/10.1111/jgs.17513

this project will increase the availability of ventilator-dependent beds for individuals with various forms of coverage.

5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

The IE completed an analysis of inpatient claims for mechanical ventilation services rendered between 2018 and 2023 for residents of the service area aged 18 or older. The Primary Diagnosis Related Group (DRG) codes related to this analysis included 003 (ECMO or tracheostomy with mechanical ventilation), 004 (tracheostomy with mechanical ventilation), 207 (respiratory system diagnosis with ventilator support for more than 96 hours), 208 (respiratory system diagnosis with ventilator support for less than or equal to 96 hours), 870 (septicemia or severe sepsis with mechanical ventilation), 871 (septicemia or severe sepsis with mechanical ventilation with major complication or comorbidity), and 872 (septicemia or severe sepsis with mechanical ventilation without major complication or comorbidity). These codes should be representative of individuals at risk for long-term ventilation use at the Applicant facility. The following data reveals pertinent sociodemographic information about those receiving ventilator care:

- Age – Patients receiving mechanical ventilation care were largely 65 years of age or older (63.4 percent). Approximately 10.6 percent of patients were between the ages of 20 and 44 years old, 25.6 percent were between the ages of 45 and 64, 24.8 percent were aged 65 to 74 years old, 24.4 percent were between the ages of 75 and 84, and 14.3 percent were 85 years old or older. Another 0.4 percent of patients were aged 15 to 19 years old.
- Insurance coverage – Throughout 2018 to 2023, 69.3 percent of patients were insured by Medicare and 12.4 percent were insured by Medicaid. Another 15.7 percent of patients utilized commercial insurance and 2.7 percent used other insurance coverage or self-pay.
- Gender – Of the patients receiving mechanical ventilation, 50.6 percent of patients were male, and 49.6 percent were male.
- Race/ethnicity – Throughout 2018 to 2023, a majority of patients were white (86.7 percent). Patients identifying as Black or African American made up 6.6 percent of the patient population. Another 0.9 percent of patients were Asian, 0.4 percent identified as American Indian or Alaska Native, and 0.1 percent reported being Native Hawaiian or other Pacific Islander. Individuals identifying as another

race or ethnicity made up 5.2 percent of these claims. Furthermore, 2.4 percent of these patients reported being Hispanic or Latino.[18]

Current Utilization of Ventilator Services

To better understand the impact of the conversion of subacute care beds to ventilator-dependent beds, the IE evaluated occupancy of the Applicant facility by bed type. To do so, the IE consulted NYS Department of Health's "Nursing Home Weekly Bed Census: Beginning 2009" database. Since January 2024, 53 percent of the 89 census reports indicated that there were no ventilator-dependent beds available at the Applicant facility. The average number of available ventilator-dependent beds over this reporting period was 1.1 beds, highlighting the need for expanded bed capacity to accommodate additional ventilated patients.[19] Furthermore, the Applicant reports that, in 2025, the occupancy rate for general subacute care beds was 68.1 percent. This indicates that capacity constraints are more substantial among specialized bed types, such as those offering ventilator care, while general subacute care beds often remain unused.

The proposed project will result in increasing the availability of ventilator-dependent beds by 50 percent and decreasing the subacute care bed count by 75 percent. This may result in decreased access to general subacute care. However, as detailed further in Potential Impacts Question #2, subacute care beds are much more widely available in the Applicant service area than ventilator-dependent beds. Furthermore, as evidenced by Applicant census data and meaningful engagement responses, it appears that the need for additional ventilator-dependent beds is substantial. The benefit, then, of expanding ventilator-dependent bed capacity should ultimately outweigh the impact of reducing the number of subacute care beds. Still, the Applicant asserts that patients currently using subacute care beds or who require subacute care in the future may utilize ventilator-dependent beds if these are available and the need for such services surpasses that of ventilator care.

Projected Utilization of Ventilation Services

The need for mechanical ventilator services is expected to increase over the next decade.[20] This is primarily driven by an aging society and an increase in the prevalence of respiratory illnesses. The Cornell Program on Applied Demographics predicts that the

[18] Data Notes: The results shown below use the Statewide Planning and Research Cooperative System (SPARCS) as a data source. The calculated results are derived from inpatient claims for services rendered during calendar years 2018-2023 from patient county origin located in Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington Counties. The report is limited to: Inpatient Claims; Patients: Aged 18+; Primary DRG codes for Mechanical Ventilation: 003, 004, 207, 208, 870, 871, 872

[19] New York State Department of Health. Nursing Home Weekly Bed Census: Beginning 2009: http://profiles.health.ny.gov/nursing_home/

[20] Hill, A. D., Fowler, R. A., Burns, K. E., Rose, L., Pinto, R. L., & Scales, D. C. (2017). Long-Term Outcomes and Health Care Utilization after Prolonged Mechanical Ventilation. Annals of the American Thoracic Society, 14(3), 355–362. https://doi.org/10.1513/AnnalsATS.201610-792OC

number of older adults aged 65 or older in the Capital Region of New York will increase from 251,504 in 2026 to 275,110 by 2040.[21] Aging is associated with a number of chronic respiratory illnesses, cardiovascular conditions, and neurological diseases as well as increased morbidity and mortality from acute events that may result in critical illness and the need for respiratory support.[22] The number of cases of Chronic Obstructive Pulmonary Disease (COPD), for example, is expected to increase in North America by 2.4 million.[23] As such, the utilization of mechanical ventilation services is expected to increase primarily among older adults. Utilization among other medically underserved groups will mirror shifting population dynamics and trends in the vast array of illnesses or injuries resulting in respiratory failure or complication.

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

There are currently 54 nursing homes in New York State which offer ventilator-dependent care. The Applicant facility is the only facility in the Capital Region of New York offering adult ventilator-dependent beds. The nearest facilities to the Applicant are detailed in Table 1 below.

Table 1. Facilities with Ventilator-Dependent Beds Near the Applicant Service Area

Facility	Number of Ventilator-Dependent Beds	Distance from Applicant
Northeast Center for Rehabilitation and Brain Injury	30	67.8 miles
Oneida Health Rehabilitation and Extended Care	11	104 miles
Taconic Rehabilitation and Nursing at Hopewell	26	106 miles
Bridgewater Center for Rehabilitation & Nursing LLC	12	128 miles
Bishop Rehabilitation and Nursing Center	5	128 miles

Source: NYS Health Profiles

As shown above, the nearest facility that offers ventilator-dependent beds is located nearly 68 miles, or approximately an hour-and-20-minute-drive, from the Applicant facility. Instead, NYS Health Profiles shows that most home facilities with ventilator-dependent beds are located in New York City (26), Long Island (nine), and the Hudson Valley Region (eight). These regions make up 69.6 percent of New York State's

[21] Cornell Program on Applied Demographics, County Projections 2018: https://pad.human.cornell.edu/counties/projections.cfm

[22] World Health Organization. (2024, October 1). *Ageing and health*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

[23] Boers, E., Barrett, M., Su, J. G., Benjafield, A. V., Sinha, S., Kaye, L., Zar, H. J., Vuong, V., Tellez, D., Gondalia, R., Rice, M. B., Nunez, C. M., Wedzicha, J. A., & Malhotra, A. (2023). Global Burden of Chronic Obstructive Pulmonary Disease Through 2050. *JAMA network open*, *6*(12), e2346598. https://doi.org/10.1001/jamanetworkopen.2023.46598

population and 85.4 percent of the state's ventilator-dependent beds. The counties served by the Applicant service area are home to 7.6 of the state's population, but just 1.9 percent of ventilator-dependent beds, all of which are located at the Applicant facility. This indicates a significant lack of ventilator-dependent beds in the area. Furthermore, the Applicant reports that these available beds are consistently at or near-capacity. This project will not impact the distribution of beds, but, rather, will increase the bed capacity of an area with a demonstrated need for additional services.

7. What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?

Mechanical ventilation market share was determined using Statewide Planning and Research Cooperative System (SPARCS) as a data source. The IE's analysis utilized inpatient claims for mechanical ventilation services (for code details, see Scoping Question #5) rendered to residents of the Applicant service area in 2023. This analysis indicates where patients living in the service area were ventilated during care.

Table 2. 2023 Market Share for Inpatient Mechanical Ventilation Services

Facility	% Total
St. Peter's Hospital	20.2%
Albany Medical Center	15.4%
Ellis Hospital	11.5%
Saratoga Hospital	9.2%
Samaritan Hospital	9%
Glen Falls Hospital	7.3%
The University of Vermont Health Network – Champlain Valley Physicians Hospital	5.9%
Mary Imogen Bassett Hospital	4.5%
St. Mary's Healthcare	3.3%
All Others	13.7%
Adult Inpatient Mechanical Ventilation Cases 2023	**100%**

Source: SPARCS (see disclaimer on page 7)

As evidenced by the table above, most patients receiving mechanical ventilation services are seen in Albany, Schenectady, and Saratoga Springs, all of which are located within a 25-mile radius of the Applicant facility. Both St. Peter's Hospital and Albany Medical Center, which hold the greatest market share of mechanical ventilation care in the service area, are located within 35 minutes of the Applicant facility. Representatives from both facilities were contacted for meaningful engagement and supported this expansion of ventilator services. This project will ensure that these hospitals can transition patients out of the Intensive Care Unit (ICU) and into alternate care settings, such as skilled nursing facilities, that better suit the needs of the individual and their family. Hospitals should benefit from the movement of patients to more appropriate care settings as it allows for greater bed capacity and availability of resources for other individuals requiring acute care.

8. Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.

N/A

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

According to New York State Department of Health, there is currently no staffing ratio mandated per ventilated patient.[24] Still, as a licensed nursing home operating in New York State, the Applicant facility is required to maintain daily staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, licensed practical nurse, or registered nurse, of which at least 2.2 hours of care per resident per day is provided by a CNA and at least 1.1 hour is provided by a licensed nurse.[25] As a higher acuity service, it is likely that the patient utilizing these additional beds may require a greater number of available staff members and/or care time. The Applicant shares that ventilated patients have 24/7 access to nurses and respiratory therapists who work under a pulmonologist. The U.S. Centers for Medicare and Medicaid Services report a higher-than-average number of nurse staff hours per resident per day at the Applicant facility.[26]

This project entails the conversion of current subacute care beds to ventilator-dependent beds. The overall bed count will not change as a result of this project. Still, considering that these beds will be dedicated to servicing patients with higher acuity health needs, it is likely that additional staff members will need to be hired. The IE does not expect that the need for additional staff members will be significant enough to result in a staffing issue but urges the Applicant to monitor ongoing quality and staffing measures to identify potential shortcomings of its staffing level.

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.

The Applicant reports there have been no civil rights access complaints against the Applicant in the last 10 years. This aligns with the IE's search of public databases.

---

[24] New York State Department of Health. (2011, June). *Questions from Nursing Homes Applying to Enhance Vent Bed Services in New York City*. Ny.gov. https://www.health.ny.gov/facilities/cons/questions_from_nursing_homes.htm

[25] 10 NYCRR §415.13 (2023), https://www.law.cornell.edu/regulations/new-york/10-NYCRR-415.13

[26] U.S. Centers for Medicare and Medicaid Services. (n.d.). Find Healthcare Providers: Compare Care Near You | Medicare. Medicare.gov. Retrieved March 12, 2026, from https://www.medicare.gov/care-compare/details/nursing-home/335701/view-all?state=NY

According to New York State Department of Health's NYS Health Profiles, this facility consistently received fewer citations than nursing homes statewide on average.

11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.

No.

STEP 2 – POTENTIAL IMPACTS

1. For each medically underserved group identified in Step 1 Question 2, describe how the project will:
    a. Improve access to services and health care
    b. Improve health equity
    c. Reduce health disparities

The conversion of subacute care beds to ventilator dependent beds will ultimately improve access to mechanical ventilation care among all adults living in the Applicant's service area. As noted above in Scoping Question #6, the Applicant is the only facility offering adult ventilator-dependent beds in the Capital District of New York State. As such, there are just 24 beds available, and according to the Applicant, these beds are consistently at- or near-capacity. Respondents representing local hospitals in the meaningful engagement process reported that case managers regularly encounter barriers in identifying facilities with adequate capacity for ongoing ventilator care. These barriers are driven by a lack of ventilator-dependent beds at alternate care facilities with one respondent stating, "We are a vent poor region in Albany and need more beds." The expansion of ventilator services will increase the ease in which hospitals can identify and arrange post-acute care for patients. This should ultimately streamline care processes and enhance continuity of care. These beds will also ensure that hospital resources are available for patients with an acute need for ventilation by transitioning patients to more appropriate care settings and freeing up beds, ventilators, and staff.

The additional ventilator-dependent beds will also ensure that more patients can receive this type of care at the Applicant facility. For patients residing in the counties immediately surrounding the Applicant, this enables patients to receive care close to home and enhances the ability of loved ones to visit during their course of care. Of course, patients in farther counties, particularly those residing in the North Country, will still be required to travel long distances to the Applicant facility. This project will not reduce the distance to care or ease in which visitors can access the facility from farther counties. However, this will result in increased regional capacity and potentially reduce the need for residents to travel across state borders for care.

This project may also increase the availability of more affordable care. Little research has been done to identify the exact cost figures of mechanical ventilation in acute care

settings compared to that of skilled nursing facilities. Still, it is possible that the transfer of a patient to an alternate care setting may reduce overall healthcare costs when compared to a stay in the ICU or other hospital facilities. An early study on the cost of care for a ventilated patient at a long-term acute-care facility, which provides similar services as skilled nursing facilities with ventilator-dependent beds, found that services in this alternate setting cost approximately $20,000 less than when patients are not transferred out of the hospital. These researchers also identified that hospitals incurred an average of $16,000 in uncompensated care per patient when they are not transferred.[27] While this 2000 study might not be exactly exemplary of the cost savings a patient might experience today when receiving care at a skilled nursing facility, the same logic may apply. This would ultimately reduce costs for both patients and hospitals, particularly if the individual being cared for has low income or is underinsured.

Overall, it is expected that the conversion of beds will have the most substantial impact on groups that utilize prolonged ventilation services at greater rates and/or experience disparate access to these services. In considering the nature of this service, the composition of patients currently utilizing ventilator services in the Applicant service area, and the extensive disparities noted in Scoping Question #4 above, the groups expected to be most impacted by the proposed project include older adults, people living with a prevalent infectious disease or condition or a disability, people living in rural areas, people with low income, racial and ethnic minorities, and people with public healthcare coverage. This project may ultimately improve health equity and reduce health disparities for these medically underserved groups.

2. For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.

In order to complete the proposed project, existing subacute care beds will be converted to ventilator-dependent beds. These beds must be fit with the adequate space for the mechanical ventilator and associated equipment. The Applicant will, therefore, experience a decrease in the availability of beds for subacute care. The conversion of twelve of these beds will result in just four beds available for subacute care. It is possible that the service area will experience a decrease in access to this level of care as a result.

However, subacute care beds are much more widely available in the Applicant service area than ventilator beds. The Applicant is the only facility offering ventilator-dependent care in the 17 counties but is just one of 64 facilities offering residential healthcare, such as subacute care. These facilities are located throughout 15 of the 17 counties of the service area, excluding Hamilton and Schoharie Counties. As such, subacute care beds are expected to be more widely available and more equitably distributed throughout the

[27] Seneff, M. G., Wagner, D., Thompson, D., Honeycutt, C., & Silver, M. R. (2000). The impact of long-term acute-care facilities on the outcome and cost of care for patients undergoing prolonged mechanical ventilation. *Critical care medicine*, *28*(2), 342–350. https://doi.org/10.1097/00003246-200002000-00009

service area. A representative from one of the local hospitals who participated in the Meaningful Engagement process reported that it is easier to find support for patients requiring residential healthcare when compared with that of ventilator-dependent patients. The individual reported, “We have a pretty good footprint in this region of subacute beds.” Therefore, the decrease in subacute care beds occurring as a result of this project is not expected to drastically impact access to care, health disparities, or health equity for these patients.

Furthermore, the Applicant, which offers pediatric services, traumatic brain injury care, and ventilation for pediatric and adult patients, serves a more medically complex patient population than other residential healthcare programs. The conversion of subacute care beds to ventilator-dependent beds represents the Applicant’s increased specialization and ability to offer quality care to a higher acuity patient population.

Overall, the IE does not believe that the conversion of subacute care beds to ventilator-dependent care beds will substantially or negatively impact medically underserved communities living in the service area who require subacute care. In considering the ventilator-dependent bed capacity constraints evident in the Applicant service area and the demonstrated need for additional ventilator care in these zip codes, it is the IE’s belief that the benefit of offering additional ventilator services will far outweigh any unintended impacts of the loss of subacute beds. Instead, this project is likely to improve access to prolonged mechanical ventilation care for all residents, particularly among those who are considered medically underserved and utilize prolonged ventilation services at greater rates and/or experience disparate access to these services. This may ultimately improve health equity and reduce health disparities for all medically underserved groups that require ventilation.

3. How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.

According to the CMS Skilled Nursing Facility Cost Report, the Applicant nursing home experienced a net income from service to patients, which considers unreimbursed care, contractual adjustments, and charity discounts, of $1,931,449. As a for-profit nursing home, which is not required to provide a minimum amount of indigent care, the IE is unable to determine if indigent care was provided and if so, how much this amounted to. Still, the amount of indigent care provided by the Applicant is not expected to be impacted by the proposed project, as there will be no net change in bed count or patient volume for the Applicant facility.

4. Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.

The patients utilizing the affected services will most likely be transferred from a hospital or other acute care facility in the service area. As such, transporting a ventilated patient

would most likely be done via ambulance or ambulette to maintain access to appropriate care professionals and equipment and minimize the risks associated with transferring an individual who is ventilator dependent. The referring hospital may arrange transportation through their own fleet of ambulances or ambulettes, if available. If this option is not feasible, transportation for the patient may be arranged through private or public options with the assistance of the referring hospital staff and/or the Applicant facility. The Applicant employs an on-site social work team who may be able to identify transportation options for patients planning to receive care there. Available transportation options are explored below. However, with such a wide service area, this is not intended to be comprehensive.

Transportation Options for Patients

Ambulance/Ambulettes – Patients may utilize Mohawk Ambulance Service which services multiple counties in the service area and offers Specialty Care Transport for ventilator management. Each county in the service area also has multiple ambulance services offering basic or advanced life support, which may assist in transporting a ventilated patient.[28]

Medicaid Transportation – Medicaid patients in need of transportation to a nursing home for ongoing ventilator care may utilize the state's designated Medicaid transportation broker responsible for identifying potential vendors. In the Applicant service area, the Medicaid transportation broker is Medical Answering Services, LLC, which can be contacted at 866-932-7740.

Transportation Options for Visitors

Ensuring ongoing access to the Applicant facility would be most pertinent for patient visitors and family members traveling to and from the nursing home. However, transportation is a pervasive barrier faced by community members residing in the service area as 41.9 percent of residents live in a rural area. In these areas, public transportation systems are scarce and lack bus and train stops near to residents' homes. Still, approximately 9.4 percent of households in the service area lack access to a vehicle.[1] Additionally, this service area is expansive, spanning a total of 17 counties in the Capital Region, Mohawk Valley, and North Country of NYS. As a result, a proportion of residents will be required to travel far distances to visit a ventilated patient at the Applicant facility. While this project will increase the regional capacity of ventilator-dependent beds, this project will not address transportation barriers or increase the ease in which family members or loved ones living in farther counties can visit the nursing home resident.

[28] New York State Department of Health (2025): Listing of Ambulance and Advanced Life Support First Response Services in New York

Most visitors are likely to arrive via car where they will be able to use on-site parking. This includes ADA accessible parking. Public transportation options to the Applicant nursing home are explored below.

By Bus:

- Capital District Transportation Authority (CDTA) Bus 351 – Services westbound/eastbound to and from Rotterdam Industrial Park to Gerling St. and Sheridan Ave. Stops on Hillside Ave approximately 0.2 miles, or a five-minute walk, from the Applicant facility.
- CDTA Bus 810 – Schenectady Shuttle servicing Schenectady neighborhoods and Schenectady High School. Stops on Hillside Ave approximately 0.4 miles, or a ten-minute walk, from the Applicant facility.
- CTDA offers routes through Albany, Schenectady, Rensselaer, Saratoga, Montogomery, Warren, and Washington. Transfers can be made along these lines to routes local to the Applicant facility.
- Greyhound bus routes reach up into the North County and Mohawk Valley. Transfers would be necessary to arrive for care at the Applicant facility. The nearest Greyhound bus stop is located approximately 3.5 miles, or a twelve-minute drive from the Applicant facility.

By Train:

- Amtrak – The Adirondack, Empire Service, Ethan Allen Express, Lake Shore Limited, and Maple Leaf routes all stop in Schenectady. The nearest Amtrak station to the Applicant facility is located three miles away, or a ten-minute drive.

5. Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

This project is not expected to reduce architectural barriers for people with mobility impairments.

6. Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law § 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?

N/A

<u>Meaningful Engagement</u>

7. List the local health department(s) located within the service area that will be impacted by the project.

- Schenectady County Public Health Services
- Albany County Department of Health
- Clinton County Health Department
- Columbia County Health Department
- Delaware County Public Health
- Essex County Health Department
- Franklin County Public Health
- Fulton County Public Health
- Greene County Public Health Department
- Hamilton County Public Health
- Montgomery County Public Health
- Otsego County Health Department
- Rensselaer County Department of Health
- Saratoga County Department of Health
- Schoharie County Public Health
- Warren County Public Health
- Washington County Public Health Service

8. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?

The IE attempted to contact representatives from all 17 county health departments in the service area. However, just eight individuals from health departments in Columbia, Fulton, Warren, Washington, Green, Delaware, and Ostego Counties provided a response for the purpose of the HEIA. All health departments were contacted a minimum of three times to provide a response. Of the public health professionals who participated in the meaningful engagement, four individuals were in support of the proposed project and four were unsure. This uncertainty was primarily driven by a lack of data specific to their county's utilization of or need for ventilator-dependent services. The following verbatim quotes were provided:

> *"Without direct knowledge of the need for additional ventilator beds I do not know the specific need. These individuals require specialized care that many families cannot provide in the home. When these beds are needed you want them to be as close to family support as possible. Families have enough of a burden in situations where this level of care is needed without having to drive for a considerable amount of time to advocate for and provide support to their loved one."*

> *"There is no way to know if this conversion will help the people of Warren County. We do not have data showing how many people actually need this type of service or what the shortage is in our area. Without this information our agency is unable to support or not support this project."*

9. Meaningful engagement of stakeholders: Complete the “Meaningful Engagement” table in the document titled “HEIA Data Table”. Refer to the Instructions for more guidance.

This data table is complete.

10. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

Findings from the meaningful engagement process aligned with the IE’s conclusions that any individual living in the Applicant service area may be impacted by the proposed project. This is especially true considering that the individuals utilizing ventilator services may require this type of care due to any number of injuries or illnesses resulting in respiratory failure. An evaluation of disparities faced by medically underserved communities at risk for acute respiratory failure suggests that the groups expected to be most impacted by the proposed project may include older adults, people living with a prevalent infectious disease or condition or a disability, people living in rural areas, people with low income, racial and ethnic minorities, and people with public healthcare coverage.

11. How has the Independent Entity’s engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

The IE sought the input of facility employees, residents, community leaders, and local health department staff for the purposes of this assessment. Outreach and engagement methods are detailed below. A total of 30 individuals provided a response. Of those successfully engaged, 25 respondents were in support of the project, and five individuals were unsure about their support.

Meaningful Engagement Methods

The IE developed a survey about the proposed conversion of subacute care beds to ventilator-dependent beds in English and Spanish. Translation of the survey into Spanish was done using a Certified Translation Service. Outreach was carried out on-site at the Applicant facility using physical outreach material such as flyers, posters, and paper surveys in order to capture the insight of the facility’s employees, residents, and/or visitors. Patients, visitors, and employees were encouraged to share their perspective on the proposed project through the online survey or by filling out a physical copy. In addition to sociodemographic questions, the survey contained dichotomous and open-ended questions about the respondents’ opinion on the proposed project. This helped to identify the level of support for the project, the potential impacts of the project, and the groups most affected. Twenty individuals provided a response to this survey. Survey results are summarized below and in Appendix A.

A similar survey was developed to gather input from community-based organization leaders, healthcare partners, and health department staff. This survey asked identical

questions about the respondents' support for the project and how they think this might impact the communities they serve. Other questions from this survey helped to develop a sociodemographic profile of the communities represented by the responding organization. This survey was disseminated among community leaders who were not contacted for an interview or were otherwise unable to provide an interview. With such an expansive service area, the IE prioritized interview and focus group feedback for the engagement of more local organizations, such as referring hospitals, non-profits that support local families, and the Schenectady County Public Health Services.

However, after extensive outreach to 35 different community leaders, only one individual provided an interview, and nine community leaders answered the digital survey. The interview summary and survey responses are explored below. Survey results are summarized in Appendix B. It is important to note that despite repeated outreach, the IE was not successful in obtaining the input of local community-based organizations. This is discussed in Question #12 below.

Survey for Facility Residents, Visitors, and Employees

As stated above, the IE deployed a survey on-site at the Applicant facility to capture the feedback of individuals receiving services, providing services, or loved ones of residents. This allowed the IE to obtain input from individuals who are familiar with the Applicant facility and the services offered there. Twenty individuals provided a response to the survey. Seventeen of these individuals were employees of the facility visitors, one individual was a resident of the facility, and two were visitors or family members. All responses received were in English.

The survey consisted of 12 questions, the majority of which focused on respondent demographics. These questions enabled the IE to develop a socioeconomic profile of the populations served by the Applicant hospital, as well as those likely to be affected by the proposed project. Respondents were also asked to indicate whether they supported the project, opposed it, or were unsure. The findings are discussed below, and summaries of all survey questions are provided in Appendix A.

Nineteen of the twenty survey respondents were in support of the project. The remaining individual was unsure about their support, though they did not elaborate on this uncertainty. The demographics of the respondents largely reflect the demographics of the service area. These individuals primarily identified as white (80 percent), followed then by Asian (15 percent), and Black or African American (five percent). None of the respondents reported that they were Hispanic or Latino. One person preferred not to share their race or ethnicity. Most respondents (90 percent) identified as female. Of the individuals who knew their healthcare coverage status and were willing to respond, 15 individuals were commercially insured, one individual had low income and was a Medicaid recipient, and one was insured by Medicare. Three people were 65 years of age or older, two individuals live with a disability, and one person identified as an immigrant. The following sentiments, which align with the IE's assessment of the project, were shared by respondents.

"It would be beneficial to the community."

"Facility would benefit from ventilator beds due more available ventilator beds in the Capital district that are needing long term care. Both parties would benefit from more available beds being closer to loved ones."

"My name is Lisa Marotta. I am the mother and Legal Guardian of [Patient Name][29], Vent Patient, Resident of Pathways. Before [Patient Name] was accepted at Pathways, I looked at several facilities in New York with assistance from OPWDD. Several appeared to be poorly run and when going on days scheduled, I was treated poorly. [Patient Name]'s transition counselor recommended Pathways. (Also there weren't many to choose from). My son has been the healthiest he has ever been since admission about 9-10 years ago. The staff are exceptional. The need for more vent beds in this area is crucial. The beds should go to Pathways as they have shown again and again they can handle them with exceptional care."

Community Leader and Professional Survey

The community leader survey ensured that the feedback of healthcare partners and health department staff could be considered for the purposes of this assessment. These survey questions largely aligned with those asked of patients, visitors, and employees, though additional details regarding the type of services provided by the responding organization and the communities receiving these were asked of respondents. One healthcare partner and eight health department staff members from the 17 surrounding counties provided a response. These organizations engage patients and community members from all sociodemographic backgrounds including individuals of all races and ethnicities, ages, gender identities and sexual orientations, immigration status, and income and insurance status. The needs of these medically underserved groups should therefore be considered in respondents' survey answers. Five individuals were supportive of the proposed project and four were unsure. One healthcare partner, in particular, who regularly refers patients to the Applicant facility for ongoing ventilator care was supportive of the proposed project and provided the following statement. The statement largely aligns with the findings of this HEIA.

"The community could certainly use these beds to help with capacity constraints at all area and state hospitals. We are a vent poor region in Albany and need more beds."

Meanwhile, local health department staff reported their uncertainty regarding their support for the project. This was primarily related to a lack of knowledge surrounding the need for ventilator-dependent beds among community members. Please see Question #8 above for more details about local health department staff's participation in this assessment.

[29] Patient name has been redacted.

Listening Session

The IE conducted one listening session with a case manager from a healthcare partner which regularly refers patients to the Applicant facility for ventilator services. This individual was in support of the project and stressed that this will help to alleviate capacity constraints and enhance the continuum of care for individuals requiring ongoing ventilator care. This individual noted that they regularly encounter barriers to coordinating care for ventilator-dependent patients due to a lack of available beds. According to the respondent, this often results in sending patients to ventilator-dependent units three or four hours away, such as facilities in New York City, which is inconvenient and burdensome among service area residents. This impacts patients experiencing acute injury and chronic illness alike. Furthermore, this respondent reported that there is a "good footprint in this region of subacute beds," emphasizing that the conversion of subacute care beds to ventilator-dependent beds will not result in an undue capacity constraint for individuals requiring care for injuries or illnesses of lower acuity. Instead, the respondent underscored the importance of enhancing options for patients with high acuity care needs. The respondent noted that "being able to have a strong partner that can work with us to have continuity of care for these patients would be really welcome." This response aligns with the IE's conclusions regarding the potential impact of the proposed project.

12. Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.

Unfortunately, after extensive outreach to eleven different community-based organizations operating in the Applicant service area, the IE was unable to successfully receive feedback from this group for the purpose of the HEIA. As noted above, the IE follows a standard practice of reaching out numerous times to stakeholders. This is evidenced by the "Unsuccessful Meaningful Engagement Attempts" section on the attached scoping sheets' Meaningful Engagement tab. One community-based organization leader noted that they consulted their facility's board and all members agreed that this was "not an area [they] could make an informed judgement on" and declined to provide feedback. It is very likely, in considering the specialized services impacted by this proposal, that other community-based organizations felt similarly which resulted in not responding to outreach attempts. These outreach efforts are documented in the attached Scoping Sheets.

STEP 3 – MITIGATION

1. If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:
    a. People of limited English-speaking ability
    b. People with speech, hearing or visual impairments

c. If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?

Mitigation Question #3 below describes how the Applicant can effectively communicate the proposed project to impacted stakeholders. The IE expects that a majority of the communication regarding this project will take place with healthcare partners in the community, rather than directly with potential patients, given the nature of the service. Still, language access services are essential to effectively communicating with patients and community members who speak a language other than English and people with speech, hearing, and/or visual impairments. As explored in Scoping Question #2, approximately 8.4 percent of individuals living in the service area report speaking a language other than English in the home, including 3.4 percent of residents who speak another Indo-European language and 2.7 percent who speak Spanish. Individuals reporting hearing difficulties and vision difficulties make up 3.9 percent and 2.2 percent of the service area, respectively.

The Applicant reports that the facility is equipped with language and communication access services to ensure that all patients and their family members can effectively engage with the patient's care team. The Applicant also reports that the facility is staffed by multilingual professionals who also provide valuable support to individuals who speak a language other than English. These employees and language access services may enhance communication of the impact of the additional ventilator-dependent beds to potential and current patients and family members.

2. What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?

Based on the findings of this HEIA, the IE does not believe that additional changes to the proposed project are necessary. As demonstrated by Scoping Question #6 above, the Applicant is the only skilled nursing facility offering ventilator-dependent beds in the Capital District region of New York and these beds service individuals from 398 residential zip codes across 17 counties. The Applicant also reports that the current ventilator-dependent beds available at this facility are regularly at- or near-capacity, which often results in care coordination issues for hospital staff members attempting to identify appropriate care settings for patients requiring ongoing ventilation support. This indicates a clear service gap, which may be ameliorated by increasing the number of ventilator-dependent beds at the Applicant facility.

While this project will require the conversion of subacute care beds to ventilator-dependent beds, the IE does not believe that this will substantially or negatively impact medically underserved communities living in the service area who require subacute care. This is especially true in considering that there are significantly more residential healthcare programs offering subacute care throughout the service area than those with ventilator units. Instead, it is the IE's belief that the benefit of offering additional ventilator services will far outweigh any unintended impacts of the loss of subacute care

beds. This will benefit all patients who require mechanical ventilation services but will have the greatest impact on groups at increased risk for acute respiratory failure, groups who utilize prolonged ventilation services at greater rates, and/or those that experience disparate access to these services. Accordingly, the groups expected to be most impacted by the proposed project include older adults, people living with a prevalent infectious disease or condition or a disability, people living in rural areas, people with low income, racial and ethnic minorities, and people with public healthcare coverage.

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?

Given the nature of mechanical ventilation, it's unlikely that community members would anticipate the significant health issues or injuries that would necessitate prolonged ventilator care. As such, the IE does not believe extensive dialogue with the general public would be a necessary step to implementing this project. Still, the Applicant may benefit from posting signage in the facility, sending emails to individuals who are currently using or have used the Applicant's services, being present at in-person health events, and disseminating paper advertising to help effectively communicate this project with the public.

The IE believes that communication with surrounding healthcare facilities who interact with patients at greatest risk for requiring mechanical ventilation will be most pertinent for the implementation of this project. The IE encourages the Applicant to communicate this plan with hospitals across the service area, particularly those with trauma centers who may see a greater number of patients requiring ventilation due to injury. Communication to case managers and hospital social work departments charged with overseeing next steps for ventilated patients will increase awareness of the additional ventilator-dependent bed capacity in the region and may enhance the ease at which patients can access these beds. The IE may also benefit from communication with specialized pulmonologists and/or neurologists who care for patients with progressive and/or chronic illnesses that may require mechanical ventilation. For example, a neurologist may be able to advise a patient and the patient's family on the facilities available for prolonged ventilation use when presenting with a neurodegenerative disorder that typically leads to reliance on a ventilator towards the later stage of illness. Overall, communication with other healthcare partners may also foster greater collaboration between professionals and enhanced continuity of care.

4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

The proposed project will enhance access to ventilator-dependent beds – a service which has been shown to be severely lacking in the Applicant service area. It is the IE's perspective that the expansion of these services will be an apparent positive for those who require ventilation services in the service area. However, to advance equity for

patients requiring ventilation care living in this service area, which covers 17 counties across the Capital Region, Mohawk Valley, and North Country of NYS, progress must be made in increasing the availability of services that are equitably distributed across the 398 residential zip codes. While increasing the capacity of the Applicant facility is undoubtedly beneficial, patients and visitors from farther counties will still be required to travel long distances – including two to three-hour drives – to receive ventilator care here as the only nursing home to offer this level of care in these regions of New York. A care system that promotes equitable access to ventilator-dependent beds would ensure these services are available throughout all regions, including the rural areas of the Applicant service area, to reduce burdensome travel for patients and visitors.

It is not within the scope of the proposed project to suggest that ventilator-dependent units can or should be added to other facilities located throughout the Applicant service area. This, instead, would require the extensive and collaborative efforts of numerous healthcare entities and state agencies to establish a network of facilities that offer ventilator-dependent services to underserved communities. It is the IE's perspective that the Applicant is undertaking appropriate measures to increase access to care within the size and scope of an independent and sole provider of ventilator-dependent beds in the service area.

STEP 4 – MONITORING

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?

- Centers for Medicare and Medicaid Services (CMS) mandatory measures tied to the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Public Reporting
- New York State Nursing Home Quality Initiative (NHQI)
- Nursing Home Inspections
- Nursing Home Complaints and Citations

2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

The Applicant appears to collect crucial census and quality data that would measure the utility of additional ventilator-dependent beds as well as the associated impacts of the reduction in subacute care beds. The Applicant would benefit from stratification of these measures by sociodemographic information in order to identify trends in access by medically underserved groups as well as disparate health outcomes. An additional measure that might offer valuable insight into the impact of this project might include capturing the time between initial contact of a referring hospital to time of patient admission to the Applicant nursing home. This might illustrate the ease of care coordination between the referring and receiving entities, likely improved by the availability of additional ventilator-dependent beds.

STEP 5 – DISSEMINATION

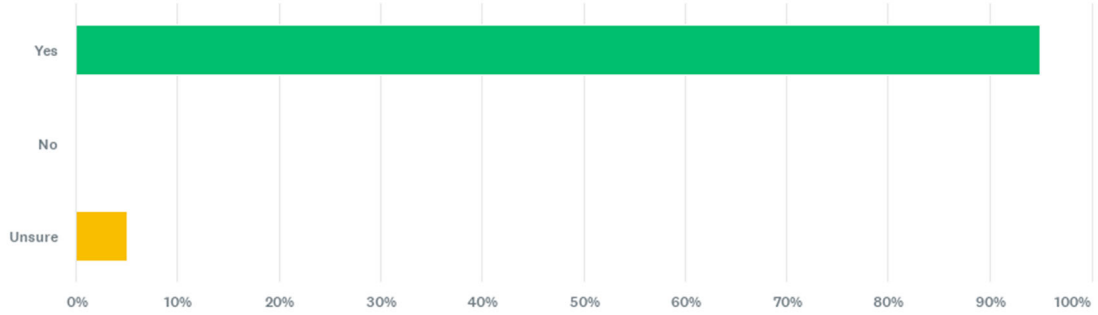
The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

OPTIONAL: Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

Appendix A - Survey for Facility Residents, Visitors, and Employees

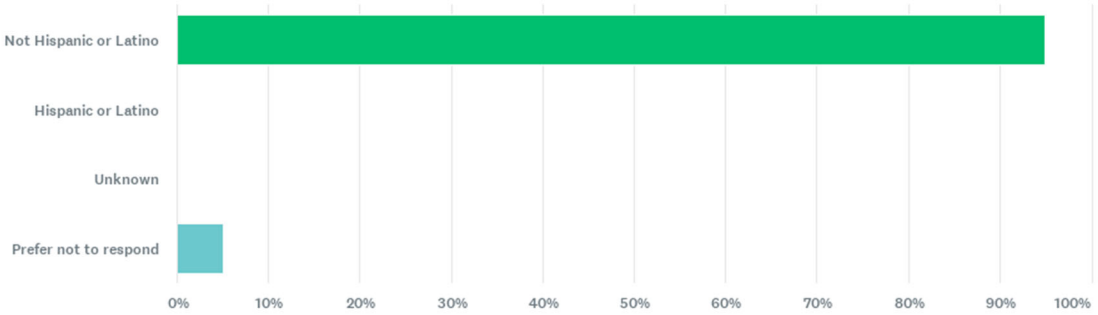
Project Support

Q4 Are you in support of the conversion of twelve subacute beds to ventilator beds?

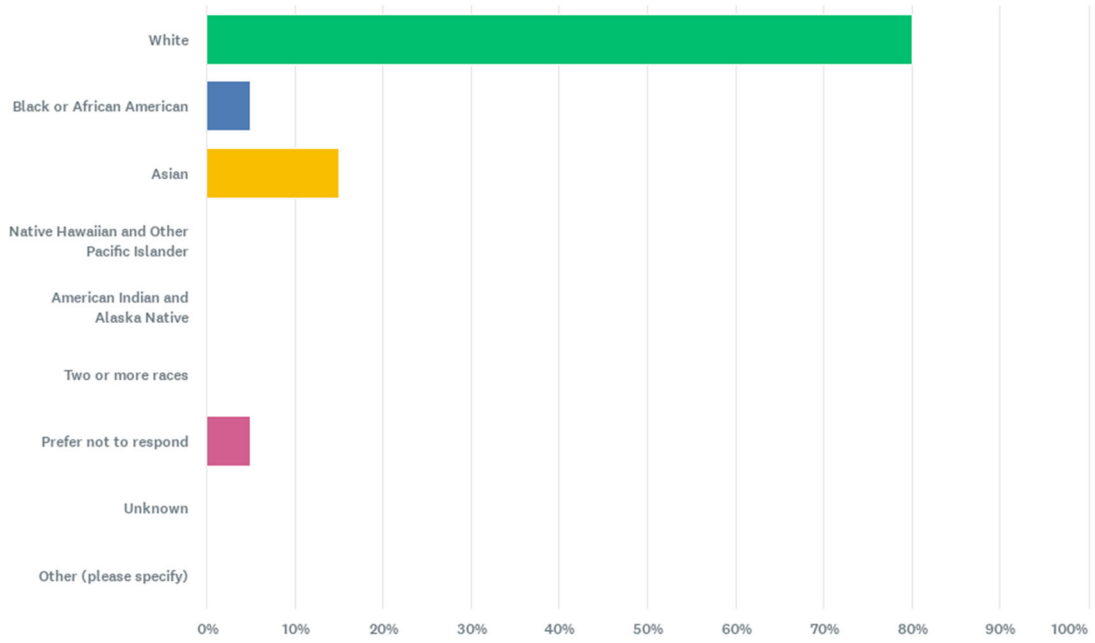


Respondent Demographics

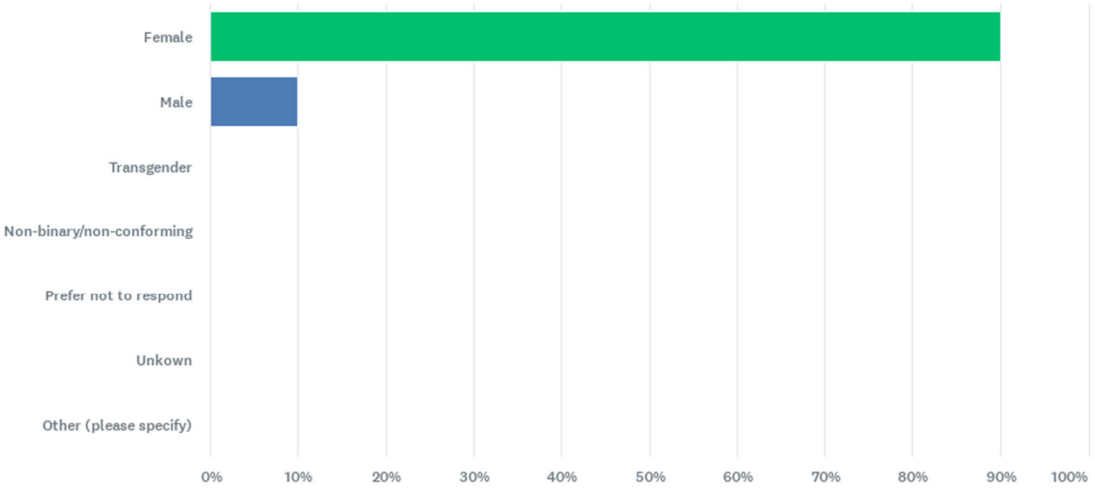
Q6 Are you Hispanic or Latino?



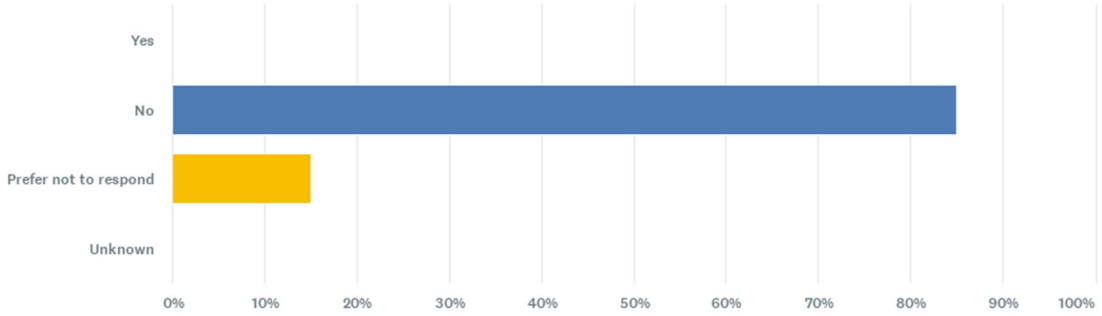
Q7 What race do you consider yourself?



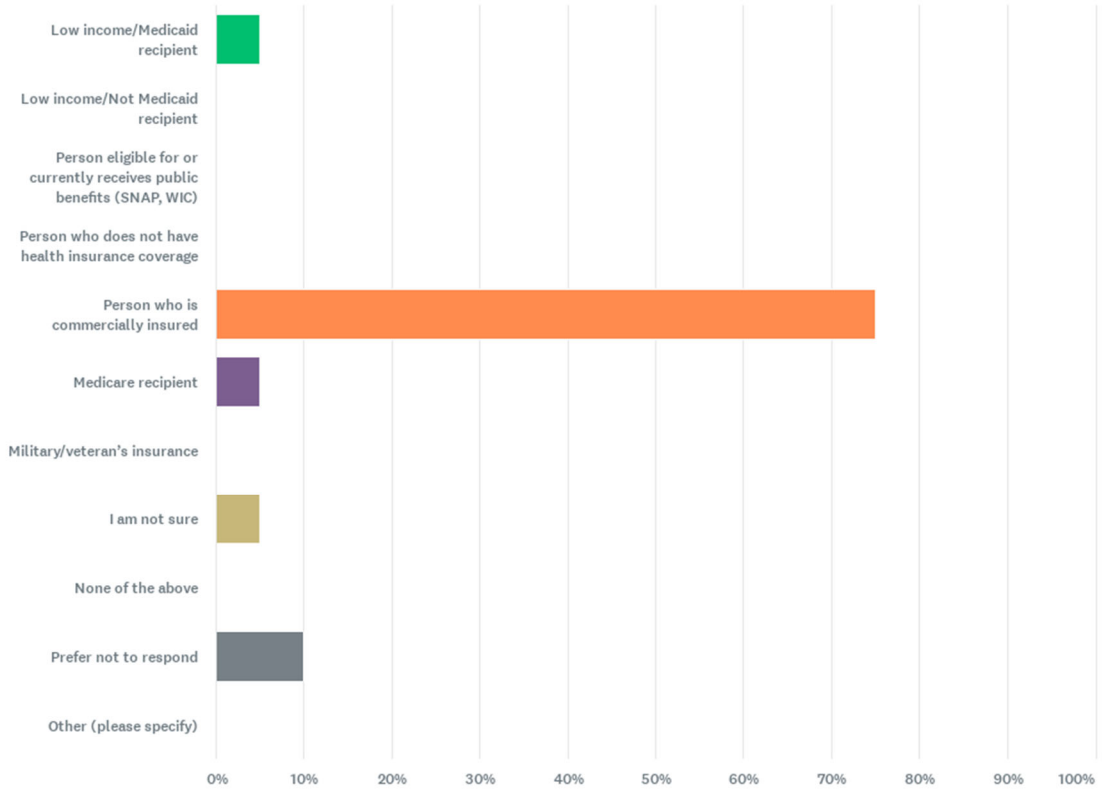
Q8 I currently identify as:



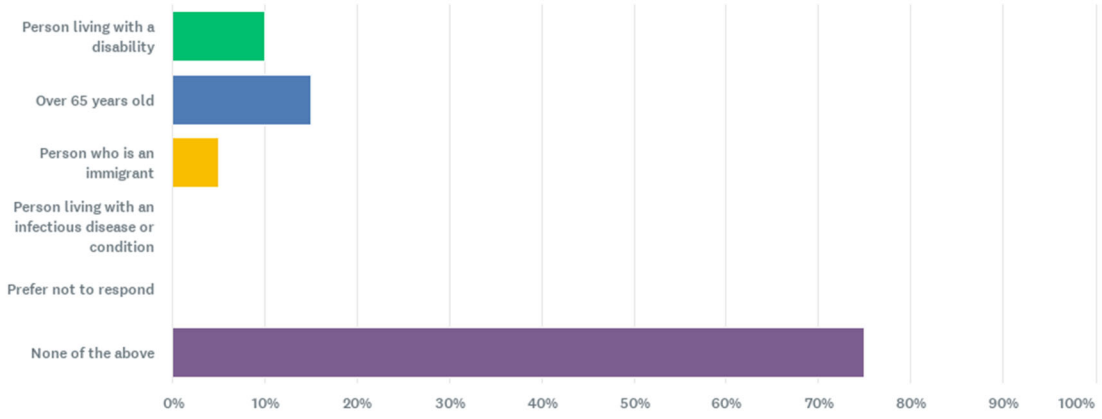
Q9 Do you consider yourself part of the LGBTQIA+ community?



Q10 What is your income/insurance status?

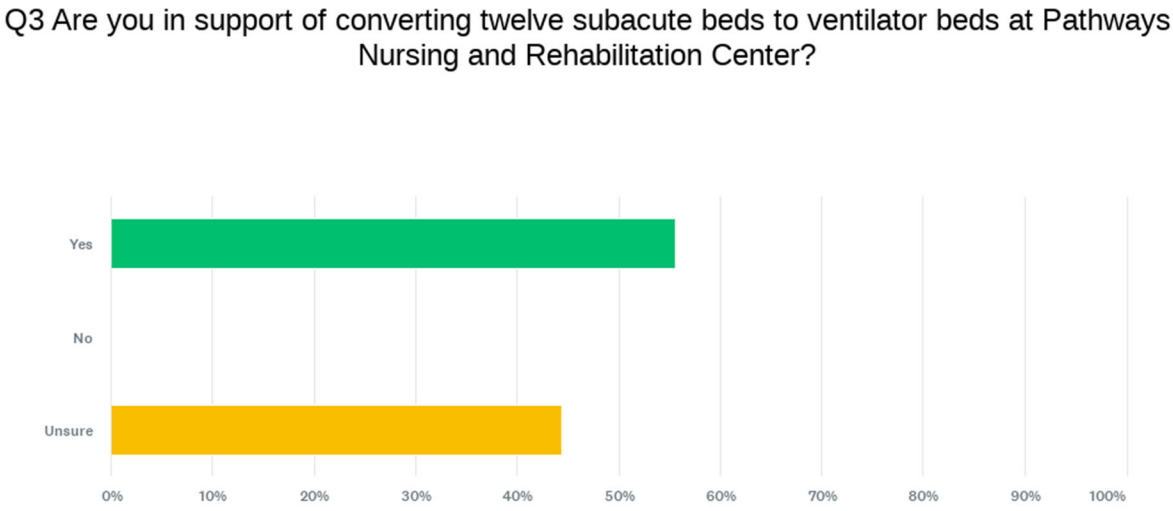


Q11 Please choose all of the following with which you identify:



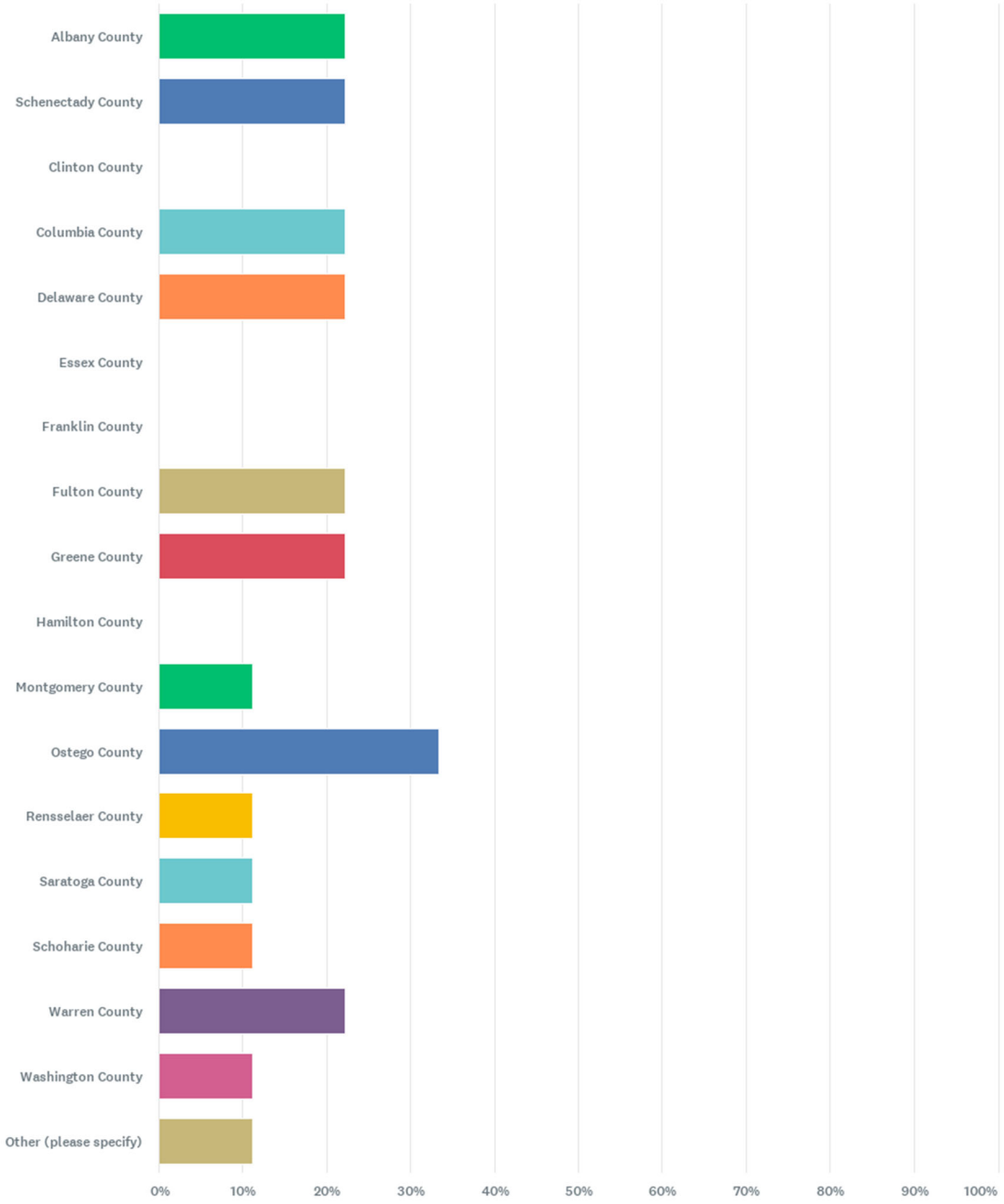
Appendix B - Community Leader and Professional Survey

Project Support

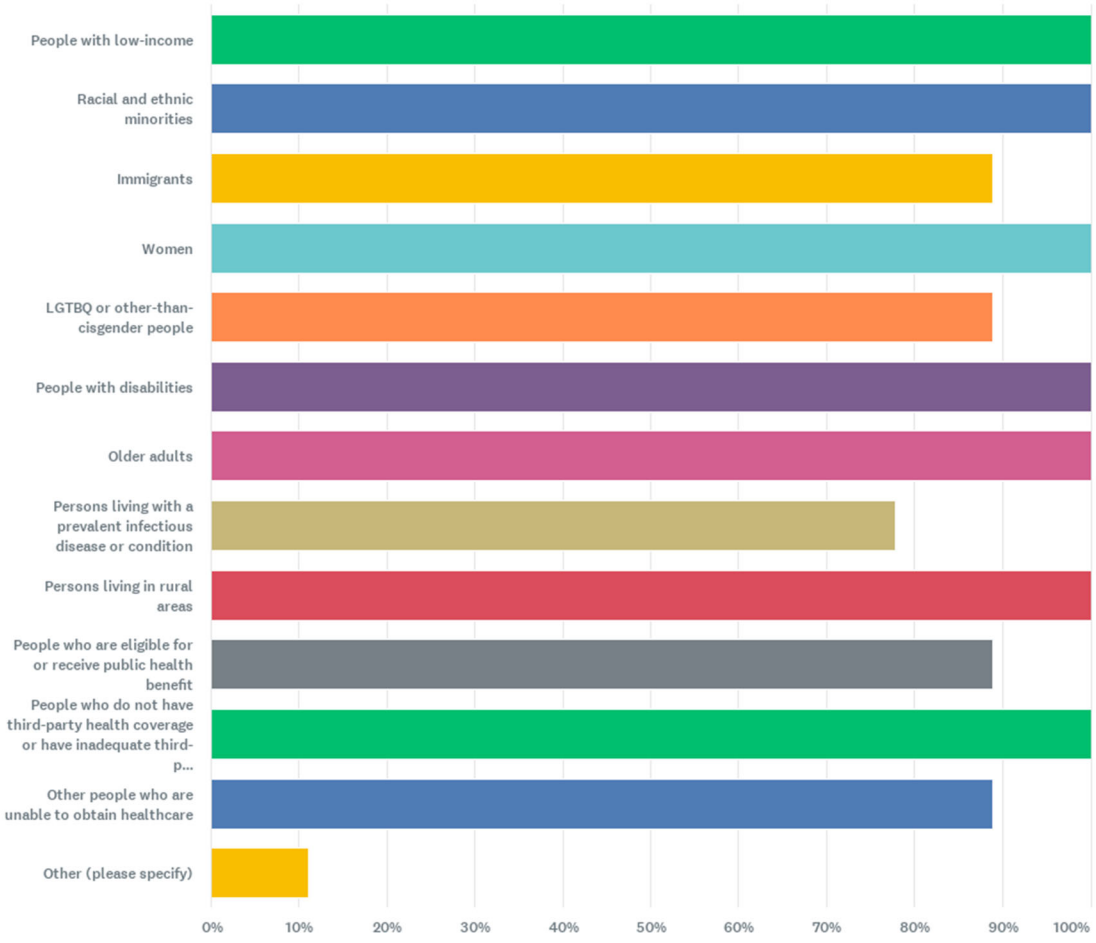


Communities Served

Q8 Please select the geographies where your community members reside (check all that apply):



Q9 Please indicate the populations your organization represents/serves (Choose all that apply):



Q10 Briefly describe the services or support provided by your organization and the populations who utilize these:

Answered: 9 Skipped: 0

#	RESPONSES	DATE
1	we provide a birth to death continuum of care as well as behavioral health and SUD services.	3/11/2026 9:28 AM
2	population health services	3/10/2026 2:31 PM
3	Direct services include: Early Intervention program, Immunization clinics, CYSHCN, maternal and infant health support	3/9/2026 4:18 PM
4	The health department serves the public. We have children's programs, immunizations, communicable disease, rabies, suicide and substance use prevention, and maternal child health.	3/9/2026 4:08 PM
5	we operate an article 28 clinic for reproductive and sexual health, treat SUD with buprenorphine, immunizations, children's programs and emergency preparedness	3/5/2026 5:25 PM
6	o Adult and Childhood Immunizations and promotion o Public Health Emergency Preparedness o Child Find and Early Intervention Program o Health Education - Collaborative Wellness Initiatives o STI/HIV / AIDS Education, Collaboration, and Testing referrals o Infection Control / Communicable Disease Follow-Up o Lead Poisoning Prevention and Education o Lyme Disease Prevention and Education o Newborn Health Program o Preschool Program for Children with Disabilities o Rabies Education and Clinics o Tuberculosis Screening and Care	3/4/2026 3:43 PM
7	Our agency serves as the local public health department for Warren County. We provide services for various populations within our County. Programs include communicable disease monitoring, chronic disease prevention/management, immunizations, lead poisoning prevention, WIC services, early intervention services, STI/HIV services, tuberculosis monitoring, health education and more.	3/4/2026 12:00 PM
8	Public Health department	3/3/2026 11:30 AM
9	We provide communicable disease follow-up and reporting to NYS, maternal and child health services, lead poisoning prevention, education and follow-up, immunization for adults and children, we offer services for migrant and seasonal workers, and we provide health education to the community.	3/2/2026 9:46 AM

---------- *SECTION BELOW TO BE COMPLETED BY THE APPLICANT* ----------

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.

I. Acknowledgement

I, William Wohltjen, attest that I have reviewed the Health Equity Impact Assessment for the Conversion of Subacute Care Beds to Ventilator-Dependent Beds that has been prepared by the Independent Entity, OckhamHealth Strategists.

William Wohltjen

Name

Administrator

Title

Signature

4/27/2026

Date

II. Mitigation Plan

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.

New York State Department of Health

Health Equity Impact Assessment

Applicant: Pathways Nursing and Rehabilitation Center

Project Title: Conversion of Subacute Care Beds to Ventilator-Dependent Beds

Applicant Acknowledgement and Mitigation Plan

The Applicant, Pathways Nursing and Rehabilitation Center, hereby acknowledges receipt of the Health Equity Impact Assessment (HEIA) conducted by the Independent Entity (IE), OckhamHealth Strategists, from January 16th, 2026, to March 31st, 2026, for the project titled above.

Based on the IE's findings, this project is not expected to have an adverse impact on health equity. The conversion of twelve subacute care beds to ventilator-dependent beds will expand access to this critically needed service in the Capital Region, where Pathways is the only skilled nursing facility offering adult ventilator beds. This will address capacity constraints, improve continuity of care, and particularly benefit higher-risk populations such as older adults, people with disabilities, rural residents, low-income individuals, racial and ethnic minorities, and those with public health coverage.

Stakeholders engaged during the IE's meaningful engagement efforts widely supported the project. While the conversion will reduce subacute care beds at the facility, the Independent Entity determined this change is not expected to substantially or negatively impact medically underserved communities, given the significantly greater availability of subacute care programs throughout the broader 17-county service area.

Pathways remains fully committed to meeting the subacute care needs of the communities we serve. Although the project will reduce dedicated subacute beds at the facility, the HEIA concluded this will not create a substantial negative impact, given the significantly greater number of subacute care programs available throughout the 17-county service area.

To further mitigate any potential effects:

- Pathways will continue to operate its remaining dedicated subacute care beds
- The facility will maintain clinical flexibility to utilize ventilator-dependent beds for subacute-level care when clinically appropriate and ventilator census allows.

Although there are currently residents occupying the subacute care beds proposed for conversion, current residents will not be affected by the conversion of beds. Pathways currently utilizes some of its Traumatic Brain Injury beds for ventilator-dependent residents who also have a TBI diagnosis. These residents would be transitioned to one of the converted ventilator-dependent beds. No patient transfers will be required and no existing residents will lose access to beds. Pathways will ensure full continuity of care for all current subacute patients throughout the bed conversion process. Given the significant underutilization of traditional RHCF beds, which may be characterized as subacute care beds, there will continue to be access for non-ventilator RHCF beds.

Pathways remains deeply committed to serving both subacute and ventilator-dependent patients with the same high standards of compassionate, high-quality care. Appropriate staffing and resources will continue to support the subacute care program post-conversion. Therefore, and at this time, Pathways Nursing and Rehabilitation Center does not expect to enact a robust mitigation plan to address health equity concerns as a result of this project.